STATE MEDICAL EDUCATION BOARD OF GEORGIA

Dear Scholarship Applicant:

Enclosed are application materials for the State Medical Education Board Scholarship Program. The scholarship amount for the 2006-2007 academic year will be up to $20,000. Pending the availability of funding, scholarships may be renewed, on an annual basis, three times, providing qualified applicants with up to four scholarships.

The enclosed information includes materials describing the requirements of the program. Please note that by obtaining a scholarship you agree to practice medicine full-time (a minimum of 40 hours per week) in a Board-approved Georgia county having a population of 35,000 or fewer people according to the U. S. Census Count of 2000. You may also practice full-time, a minimum of 40 hours per week, at any facility operated under the jurisdiction of the Georgia Department of Human Resources, Georgia Department of Corrections or the Georgia Department of Juvenile Justice at the conclusion of your medical training.

In order for your application to be considered by the Board, you must submit **all** the following documents postmarked or hand delivered by **June 1, 2006**:

1. Completed Application Form (include a recent black and white passport photo)
2. Completed Certification of Residency Form (form enclosed)
3. Letter of acceptance to an accredited medical school (If your application is pending, submit all other application documents pending your acceptance)
4. Written personal statement of commitment to practice in a Board approved medical specialty in a rural area of Georgia approved by the Board
5. Completed Applicant and Parents' Financial Information Forms (forms enclosed). Provide a current copy of your Federal Income Tax Form
6. Recommendations from the three personal references named in your application
7. Copy of the personal statement from your medical school application
8. Transcript of your grades if currently enrolled in medical school
9. Selective Service Information for all male applicants (form enclosed)
10. Authorization and Release Form (form enclosed)

After receipt of all application materials, you will be required to attend a formal interview with the members of the Board. The Board also requires that each applicant complete the Myers-Briggs Type Indicator (MBTI) instrument, which is usually completed at the time of the interview.

If you desire additional information or assistance with your application, please write or call this office at (404) 206-5420.

Sincerely,

Benjamin Robinson
Executive Director

Enclosures

1718 Peachtree Street, NW, Suite 683 ● Atlanta, Georgia 30309-2496 ● Office 404-206-5420 • Fax 404-206-5428

The State Medical Education Board of Georgia

Scholarship Program

Academic Year 2006–2007

Applicant Information Bulletin

This document describes the State Medical Education Board of Georgia Scholarship Program. Program participants will be bound by contract to adhere to the provisions outlined in this document.

Please keep this Bulletin for future reference.

STATE MEDICAL EDUCATION BOARD OF GEORGIA
SCHOLARSHIP PROGRAM

PURPOSE OF THE PROGRAM

The State Medical Education Board Scholarship Program was created in 1952 to provide a supply of physicians for the medically underserved rural areas of the State and to help defray the cost of medical school for Georgia residents who desire to practice medicine in rural Georgia. The service repayable scholarship will provide up to $20,000 per year to help pay the cost of medical school in return for a contractual obligation to practice medicine full-time (a minimum of 40 hours per week) in a Board-approved Georgia county with a population of 35,000 or fewer persons.

ELIGIBLE APPLICANTS

All applicants must be legal residents of the State of Georgia and citizens of the United States. In order for an application to be considered by the Board, the applicant must be accepted into an L.C.M.E. or A.O.A. accredited four-year U.S. medical school offering the degrees of Doctor of Medicine or Doctor of Osteopathy (M. D. or D. O.). All scholarship recipients must pursue a course of study that will allow them to qualify for licensure by the Composite State Board of Medical Examiners of Georgia.

Successful applicants must exhibit a strong commitment to practice medicine in rural Georgia (a Board-approved Georgia county having a population of 35,000 or fewer persons). Additional priority will be given to those applicants who demonstrate financial need. The applicant is required to disclose his/her own financial information as well as financial information pertaining to his/her parents or guardian.

APPLICATION REQUIREMENTS

1. Completed application form
2. Completed Certificate of Residency (form provided)
3. Male applicants are required to submit evidence of having registered for Selective Service (form provided)
4. Financial information as to the ability of both the applicant and his or her parents or guardian to finance the applicant's medical education (forms provided). Provide a current copy of your Federal Income Form.
5. An essay describing the applicant's commitment to practice medicine in a rural area of the State and his/her familiarity with a rural environment
6. Letter of acceptance to an accredited medical school
7. Copy of personal statement from medical school application
8. Written recommendations from three personal references named in the application
9. Other such forms as the Board may require, including personal and interest inventory questionnaires (Myers-Briggs Type Indicator)
10. Completed Authorization and Release Form (form provided)
11. Attend the formal applicant interviews conducted by the Board

The Board is charged with receiving and acting upon all applications for scholarships made by students who are residents of Georgia who desire to become doctors and who make a contractual commitment to practice medicine full-time in an approved Georgia community.

CONTRACTUAL OBLIGATIONS

All scholarship recipients are required to sign a contract with the State Medical Education Board agreeing to the terms and conditions upon which the scholarships are granted. This contract establishes the amount of the scholarship award, the date of the contract and the corresponding census count used to determine eligible practice locations, as well as the terms and conditions of program participation pertaining to medical training, obligated service and the conditions of default and cash repayment.

For each year of full-time medical practice in a Board-approved Georgia county having a population of 35,000 or fewer persons, or at any hospital or facility operated under the jurisdiction of the Georgia Department of Human Resources, the Georgia Department of Corrections or the Georgia Department of Juvenile Justice, the recipient will receive credit for the amount of scholarship funds which he or she received during any one year in medical school. The authority for county populations is the Decennial Census Count of the United States Bureau of the Census effective at the time the scholarship contract is signed.

AWARDING AND FUNDING OF SCHOLARSHIPS

Scholarship funding is based upon the amount of funds appropriated to the State Medical Education Board by the Georgia General Assembly. The funding amount for scholarship awards during the 2005-2006 academic year will be up to $20,000 each. Upon the submission of a signed contract and verification that the student is enrolled in the medical school named in said contract, scholarship funding is authorized. Scholarship funds are disbursed directly to the medical school to address yearly tuition and fees with any remaining funds being disbursed to the student by his/her medical school.

CONTRACT RENEWAL

The contract term is one year. Contracts may be renewed for additional one-year terms for a maximum of four years. Each scholarship recipient is required to complete and submit an annual report to the Board concerning their status in training. The Annual Report includes:

A. Current and valid name, address, telephone number, fax number and e-mail address
B. Medical school enrollment status and verification of good academic standing
C. Date of graduation
D. Plans for specialization
E. Continued interest and recommitment to rural practice

APPROVAL OF RESIDENCY PROGRAMS

In order to assure that recipients complete residency programs in specialties needed in rural Georgia, your selection of residency must have prior written approval by the Board. The medical practice obligation is deferred during the completion of an approved residency training program only if the Board has approved the residency.

SCHOLARSHIP REPAYMENT OBLIGATIONS

Each recipient is required to obtain Board approval of any proposed practice location. Credit for practice repayment is applied one year of funding for each year of service rendered in compliance with the repayment provisions of the scholarship contract. Practice without written Board approval will not be credited toward the satisfaction of the contractual service obligation.

The recipient must practice full-time, a minimum of forty hours per week, in the Board- approved practice location. If a recipient changes practice location for any reason, he/she must request Board approval of any subsequent practice location.

STUDENTS DISMISSED OR WITHDRAWN

In the event a scholarship recipient is dismissed from medical school for either academic or disciplinary reasons, or a recipient voluntarily withdraws from medical school, the scholarship recipient is immediately liable for all scholarship funds received, plus accrued interest at the rate stated in the scholarship contract.

CONTRACT DEFAULT

A scholarship recipient will be considered in default under the following circumstances:

A. Failure to keep the Board informed of current address and telephone number
B. Failure to submit reports, forms, transcripts, etc., as required by the Board
C. Failure to obtain Board approval for graduate medical education
D. Failure to obtain Board approval of practice location
E. Failure to begin or complete approved practice obligation
F. Failure to maintain a full-time (minimum of forty hours per week) medical practice
G. Failure to obtain and maintain a valid medical license from the Composite State Board of Medical Examiners of Georgia

In the event the State Medical Education Board finds a scholarship recipient in default, the recipient is immediately liable for triple the principal amount of scholarship funds received.

PRACTICE LOCATION ASSISTANCE

In cooperation with other interested organizations and rural Georgia communities, the State Medical Education Board sponsors an annual Medical Fair. This function is designed to enable physicians to meet representatives from 25-30 qualifying rural Georgia communities to discuss practice opportunities in our State.

The Georgia Board for Physician Workforce maintains information pertaining to practice opportunities statewide. Many of these opportunities are rural locations eligible for repayment of the scholarship obligation. In addition, the staff of the State Medical Education Board, through contact with scholarship recipients in practice and rural Georgia communities, will provide information pertaining to practice opportunities from time to time.

OBTAINING AN APPLICATION

Applications are available from the State Medical Education Board at any time. Completed applications should be received in the State Medical Education Board office no later than June 1st for consideration.

For applications or additional information, please contact:

State Medical Education Board of Georgia
Scholarship Program
1718 Peachtree Street, NW, Suite 683
Atlanta, Georgia 30309-2496
404/206-5420 – Office Phone
404/206-5428 – Fax

Website: www.SMEB.georgia.gov
E-mail: SMEB@dch.ga.gov

Attach recent passport photo, preferably with a light background. Attach with paper clip ONLY!!

APPLICATION

State Medical Education Board Scholarship Program

State Medical Education Board of Georgia
1718 Peachtree Street, NW., Suite 683
Atlanta, Georgia 30309-2496
Telephone: 404/206-5420
Fax: 404/206-5428

Please print or type legibly

PERSONAL HISTORY:

Full Legal Name:_____
Last First Middle/Maiden

SSN: _____/_____/_____ Birthdate: _____/_____/_____ Race: _____ Sex: _____

Permanent Mailing Address:_____
Street/Apt/Box No. City State Zip

Current Mailing Address: _____
Street/Apt/Box No. City State Zip **e-mail address**

Date this address will change: _____ Current Daytime Phone: _____

Birthplace: City _____ County _____ State _____

Hometown in Georgia: _____ Age: _____ Number of Years You Have Resided in Georgia: _____

List other places of residence and the number of years in each place: _____

_____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____

Name of Spouse: _____ Spouse's Hometown: _____

Name of contact person who will always know your whereabouts:

Full Name _____ Relationship to Applicant _____

Address: _____
Street/Apt/Box No. City State Zip Phone

EDUCATIONAL HISTORY

School	Name, City/State	Year Entered	Year Graduated	Field of Study
High School				
College				

SAT Score: _____ or ACT Score: _____

MCAT Scores: Biological Science _____ Physicial Science _____ Verbal Reasoning _____ Writing _____

GPA: Last Academic Year: _____ Overall GPA: College _____ Medical School _____

Medical School You Plan to Attend:_____

If presently enrolled, please check class rising: Freshman _____ Sophomore _____ Junior _____ Senior _____

Offices and Honors:_____

_____

_____

EMPLOYMENT HISTORY

If you worked while in school during afternoons, weekends, holidays, summers, etc., give detailed information as requested:

Year	Place of Employment	Duties	Length of Employment	Estimated Total Earnings
(HIGH SCHOOL)				
Fr.				
Soph.				
Jr.				
Sr.				
(COLLEGE)				
Fr.				
Soph.				
Jr.				
Sr.				
(PRESENT EMPLOYMENT)				

Indicate How Your College and Medical School Expenses Have Been Paid:

	College	Medical School
Paid by Earnings	_____%	_____%
Paid by Parents	_____%	_____%
Paid by Scholarships	_____%	_____%
Paid by Loans	_____%	_____%
Other Sources, Please list:		
_____	_____%	_____%
_____	_____%	_____%
	100%	100%

Total Present Educational Indebtedness: $ _____ (should agree with loan amount above)

List Scholarships Received by Year, Amount and Institution: _____

_____

Other Sources of Income (if any): _____ Amount: $ _____

Amount Spouse Contributes to Your Medical Education: $ _____

The foregoing information is true and correct to the best of my knowledge and belief. I understand that if I receive and accept a State Medical Education Board Scholarship, I will be required to practice medicine on a full-time basis in a Board-approved county of 35,000 population or less,according to the U. S. Census Count of 2000, or a position with the Georgia Departments of Juvenile Justice, Corrections or Human Resources. For each year of practicing my profession in such location, I will receive credit for the amount of scholarship I received during one year of medical school. I further understand that my residency program must be approved by the Board.

_____ _____
Signature of Applicant Date

Official Notary:
I hereby certify that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, _____ (applicant's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledged before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of _____, County of _____ and State of _____,

This _____ day of _____, 2006.

_____ Notary Signature
My commission expires:
(Affix Seal)

PRACTICE PREFERENCES

Please list 3 Georgia counties in which you are interested in practicing. Your choices are limited to counties having a population of 35,000 or fewer persons, or positions with Georgia Departments of Corrections, Human Resources, or Juvenile Justice.

_____

_____

_____

REFERENCES

List Names and Complete Addresses for 3 Professional References--College Professors:

Name	Street/Apt/Box No.	City	State	Zip	Telephone Number
Name	Street/Apt/Box No.	City	State	Zip	Telephone Number
Name	Street/Apt/Box No.	City	State	Zip	Telephone Number

List Names and Complete Addresses for 3 Personal References--Persons Not Related to you by Blood or Marriage:

Name	Street/Apt/Box No.	City	State	Zip	Telephone Number
Name	Street/Apt/Box No.	City	State	Zip	Telephone Number
Name	Street/Apt/Box No.	City	State	Zip	Telephone Number

REMARKS: Information not requested in the application that you feel may be pertinent to your application.

_____

_____

_____

_____

_____

STATE MEDICAL EDUCATION BOARD OF GEORGIA
1718 Peachtree St., NW, Suite 683
Atlanta, Georgia 30309-2496

CERTIFICATION OF RESIDENCY

Full Name _____

Sex _____ Date of Birth _____ Place of Birth _____

Temporary Address _____

Telephone Number ( ) _____ Social Security # _____

Permanent Home Address _____

Parents Address _____

If Married, Name of Spouse _____

Current Address of Spouse _____

Medical School You Are Planning to Attend _____

Present College Enrollment _____

Georgia Residency Maintained Continuously Since (Year)_____ (Month) _____

High School Attended _____

Most Recent Driver's License Issued by Which State _____

Automobile(s) (If Any) Registered in Which State _____

Year and State for Which Last State Income Tax Return was Filed _____

State of Residence Claimed on Last State/Federal Income Tax Return _____

This Residence was Claimed for Whole or Part Year _____

In Which State Were You Last Registered to Vote _____ Date _____

The above information is given to the official whose signature appears below for the purpose of assisting the said official in determining my legal residency status.

Sworn to and subscribed before me this_____ day of _____, 20_____

_____ _____
Notary Public Signature Applicant Signature

Notary
Affix Seal Here

CERTIFICATION OF RESIDENCY

*<u>The Following Certification Must be Executed by the Clerk of Court of the County Where You Maintain Your Legal Residence</u>.

Based on the above information, I hereby Certify that, in my opinion, _____ _____ is and has been a legal resident of the County of _____ and the State of _____ for the past twelve (12) months or more.

Signature of Official _____

Title _____ Date _____

REQUIRED REGISTRATION FOR MILITARY SERVICE

All MALE students born AFTER December 31, 1959 must complete and submit this form with the application for scholarship consideration.

"Article 1 of Chapter 3 of Title 20 of the Official Code of Georgia Annotated, relating to definitions affecting post-secondary education, has been amended by adding at the end of said article a new Code section, to be designated Code Section 20-3-2, to read as follows:

20-3-2. Except as otherwise allowed by law, no person who is required to register for the federal military service draft under 50 U.S.C. Section 453, as amended, shall be eligible to receive any form of state funds under this chapter, including appropriations, grants, bond proceeds, or any other form of funds, unless such person has registered for the draft."

Have you registered for the draft? ____Yes ____No

If so, what is your draft number? _____

The above information is true and correct to the best of my knowledge.

_____ _____

Date Signature

_____

Print your name here

To obtain your draft, call the Selective Service System at **1-847/688-6888** toll free.

You will need your social security number to identify yourself.

To register online, go to **www.sss.gov**

"Country Doctor" Scholarship Program

APPLICANT ESSAY

The principal criteria for the award of scholarships by the State Medical Education Board are financial need and an expressed willingness to practice medicine on a full-time (a minimum of 40 hours per week) basis in a Board-approved Georgia county having a population of 35,000 or fewer persons according to the U. S. Census Count of 2000; or full-time (a minimum of 40 hours per week) at any Board-approved facility operated by or under the jurisdiction of the Georgia Department of Human Resources, Georgia Department of Corrections, or Georgia Department of Juvenile Justice. It would be helpful, therefore, if you would express your own views and feelings concerning the practice of medicine in a particular rural town or county.

Generally, we would like to get an impression of your familiarity with rural life, primary care medicine and an idea of what type of practice you envision for yourself in the future. Although you are not obligated to practice in the town or area of the state you identify in your essay, it is important to clearly state the reasons for your present interest in a particular location. (Information that may assist you in describing your choice of location may be secured from local and county government officials, local physicians, health service agency staff, Area Planning and Development Commission staff, staff at the medical college you plan to attend, the Department of Human Resources -- Primary Care Division, the Department of Corrections, the Department of Juvenile Justice and others.) Identify any sources of information you use in your essay.

PLEASE TYPE OR PRINT LEGIBLY IN BLACK INK on standard 8½ x 11" paper using 1-inch margins. Limit the essay to 300 words.

STATE MEDICAL EDUCATION BOARD OF GEORGIA

To: Parents and Guardians of Scholarship Applicants

According to Georgia Law, it is the responsibility of the State Medical Education Board of Georgia to investigate the ability of each student applicant and his or her parents to pay their own tuition during medical school.

To meet this requirement, we ask that applicant's parents complete the enclosed Parents' Financial Information and submit a copy of their 2005 Federal Tax Forms. Please provide this information as quickly as possible, but no later than June 1, 2006.

If you have questions or concerns, please contact Janice Friend at 404-206-5419.

Attachment

STATE MEDICAL EDUCATION BOARD OF GEORGIA
Scholarship Application

APPLICANT FINANCIAL INFORMATION
All information provided will remain confidential

Please respond to every question, use n/a or "0" if necessary. Please type or print legibly.

1. Full Name _____

2. Permanent Mailing Address _____
Street Apt. Number E-mail Address

_____
City State Zip Area Code/Telephone Number

3. State of Legal Residence _____

4. List the number of years (in each city) you have resided in Georgia (i.e., 18, Atlanta; 5, Rome) _____

_____

List all other states in which you have resided, along with the number of years (i.e., 4, Ohio) _____

_____

5. Citizenship: _____ U.S. Citizen _____ Resident Alien

_____ Other, please specify _____

6. Sex: _____ Male _____ Female

7. Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

8 . Will you have received your undergraduate degree by July 1, 2006? _____

List your undergraduate field of study _____

9. Expected degree (M.D./D.O.) _____ Expected date of graduation _____

10. Did you live with your parents during all or part of 2005? _____

11. Did your parents claim you as a tax exemption during 2005? _____

12. Did you receive more than $750 support from your parents during 2005? _____

13. The total size of your household during 2005 (include yourself, spouse and dependent children) _____

14. List number of dependent children and ages _____

15. Of the number in question 13, how many will be in college (full or part-time) during 2006-2007? _____

16. **Spouse Information:**

A. Name _____ Age _____

B. Hometown _____ Occupation _____

C. Employer _____

D. Will spouse attend college in 2006-2007? _____

E. Does spouse have relatives or living experience in rural areas? _____

17. **Applicant and Spouse's Resources During 2005:**

A. Applicant's wages, salaries, tips, etc. (before taxes and deductions) $_____
B. Spouse's wages, salaries, tips, etc. (before taxes and deductions) _____
C. Other taxable income (interest, dividends, etc.) _____
D. Social Security benefits _____
E. Military/Veteran's benefits _____

F. Support from Applicant's parents _____

G. Support from Spouse's parents _____

TOTAL RESOURCES $ _____

18. Monthly home mortgage or rental payment: $ _____

19. If you own a home: Year Purchased _____ Purchase Price $ _____

20. **Applicant and Spouse's Assets:**

	Present Value	**Amount of Debt**
A. Cash, savings, checking accounts1	$ _____	$ _____
B. Home (Renters, write "0")	_____	_____
C. Investments (type: _____)	_____	_____
D. Business (type:_____)	_____	_____
E. Farm (type: _____)	_____	_____
TOTAL ASSETS	$ _____	$ _____

21. Please estimate your 2006 income: Applicant $ _____ Spouse $_____

Will your combined total income differ significantly from the 2005 income reported above?_____
If yes, please explain:

_____

22. List all other types of financial aid for which you have applied (***HEAL, Stafford, In-House Medical Loans, NHSC, Military Scholarship, Osteopathic Student Loan, etc***.)

_____

_____

23. Comments or explanations of any special circumstance (give number of question to which you are referring)

_____

_____

_____

THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Applicant's Signature Date

_____ _____
Spouse's Signature Date

Official Notary:
I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____ (applicant's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of _____, County of _____ and State of _____,

this _____ day of _____, 2006.

_____
Notary Public

Affix Seal My commission expires:

STATE MEDICAL EDUCATION BOARD OF GEORGIA
Scholarship Application

PARENTS' FINANCIAL INFORMATION
All information provided will remain confidential

Please respond to every question; use n/a or "0" if necessary. Please type or print legibly.

1. Check one ❑ Father ❑ Stepfather ❑ Guardian

   A. Name _____ Age _____
   B. Street Address _____
   City/State/Zip _____
   C. Occupation/Title (even if retired) _____
   D. Employer _____ No. of Yrs. _____
   E. Hometown _____

2. Check one ❑ Mother ❑ Stepmother ❑ Guardian

   A. Name _____ Age _____
   B. Street Address _____
   City/State/Zip _____
   C. Occupation/Title (even if retired) _____
   D. Employer _____ No. of Yrs. _____
   E. Hometown _____

3. Parents' current marital status _____

4. Parents' current state of legal residence _____

5. Total size of parents' household (include parents, applicant, and other dependent children/family members) during 2006-2007 will be: _____

6. Give information for all dependents included in #5. Include parent if he/she will attend college
.

Name	Age	School Level	Relationship to Applicant	Parent's Contribution

7. **DIVORCED OR SEPARATED PARENTS**

   A. Applicant's natural/adoptive parents are ❑ Divorced ❑ Legally Separated ❑ Separated, no court action ❑ Date of divorce/separation
   B. Other parent's name _____
   Home Address _____
   City/State/Zip _____
   Employer _____

   C. According to court order, when will/did support for applicant end? _____

	2004	2005
D. Amount of support received for student	$_____	$_____
E. Total amount of child support received for all children	$_____	$_____
F. Amount of alimony received by parent who filed this form	$_____	$_____
G. Is there an agreement specifying a contribution for applicant's education? If so, how much per year?	$_____	$_____

H. Who will claim applicant as a tax dependent for 2006? _____

8. **BREAKDOWN OF PARENTS' INCOME**

	2004	2005
A. Wages, salaries, tips - father/stepfather	$ _____	$ _____
B. Wages, salaries, tips - mother/stepmother	$ _____	$ _____
C. Interest and dividend income	$ _____	$ _____
D. Net income/loss from Business or Farm (indicate loss in parentheses)	$ _____	$ _____
E. Other taxable income:		
capital gains/losses	$ _____	$ _____
pensions	$ _____	$ _____
annuities	$ _____	$ _____
rents	$ _____	$ _____
royalties	$ _____	$ _____
trusts	$ _____	$ _____
partnerships	$ _____	$ _____
estates	$ _____	$ _____
Other, explain	$ _____	$ _____
F. Social Security benefits	$ _____	$ _____
G. All other income and benefits	$ _____	$ _____
TOTAL INCOME FROM ALL SOURCES	$ _____	$ _____

9. **ASSETS**

		Present Value	Amount of Debt
A. Cash, savings, checking accounts		$ _____	$_____
B. Home (renters, write "0") Yr. Purchased _____	Price $ _____	$ _____	$_____
C. Real estate		$ _____	$_____
Type: _____			
Type: _____			
D. Investments		$ _____	$_____
Type: _____			
Type: _____			
E. Business (type:_____)		$ _____	$_____
F. Farm (type:_____)		$ _____	$_____
TOTAL		$ _____	$_____

10. Please estimate your 2006 income: Husband $_____ Wife $_____

Will your combined total income differ significantly from the 2005 income reported above? _____

If yes, please explain _____

_____

THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____
Father/Stepfather/Guardian's Signature Date

_____ _____
Mother/Stepmother/Guardian's Signature Date

Official Notary:
I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, _____ (parent's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of _____, County of _____ and State of _____,

this _____ day of _____, 2006.

_____ Affix Seal
Notary Public

My commission expires:_____

STATE MEDICAL EDUCATION BOARD OF GEORGIA
AUTHORIZATION and RELEASE FORM

FULL LEGAL NAME OF APPLICANT: _____

TO WHOM IT MAY CONCERN:

I, _____, have filed an application with the State Medical Education
Applicant's Full Legal Name

Board of Georgia for a medical scholarship to defray the cost of my tuition and other expenses while attending medical college. I recognize that it is the responsibility of the members of said Board to determine that only those qualified persons of high character and recognized ability, who have demonstrated a financial need, are eligible for the award of scholarships. To this end, and for the entire contract period and any subsequent contractual period, I hereby authorize and request any college or school official, institution or organization and any other person or official of any firm, association or corporation, including, but not limited to, those persons whose names I have given as personal references on my scholarship application, to answer any inquires, questions, interrogatories, or furnish any information whatsoever concerning the undersigned on forms or requests which may by submitted to them by the State Medical Education Board or its authorized representative, and to appear before said Board, or its authorized representative, and to give full and complete testimony concerning the undersigned, including any information furnished by the undersigned. I hereby relinquish any and all rights to said reports, evaluations, consultations, letters of recommendation or any other information or material incident in any way to authorized reviews by the State Medical Board, or its authorized representative, and fully understand that I shall not be entitled to have disclosed to me the contents of any of the foregoing.

I hereby release and exonerate all such persons authorized by the State Medical Education Board, who shall comply in good faith with this authorization and release from any and all liability of every nature and kind whatsoever growing out of or in any way pertaining to the furnishing of such information or inspection of any document, record and other information or any investigation by said State Medical Education Board.

Further, the undersigned hereby waives absolutely any right which he/she may have under the laws of Georgia governing confidential or privileged communications, as codified in Sections 38-418, 38-419.1 of the Georgia Code Annotated, as now or hereafter amended.

IN WITNESS WHEREOF, I have set my hand and seal this _____day of _____, 2006.

_____
Applicant's Full Legal Signature

STATE OF _____ **COUNTYOF** _____

OFFICIAL NOTARY:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____,
Applicant's Full Legal Name

to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of _____, County of _____

and State of _____, this _____day of _____, 2006.

_____
Legal Signature, Notary Public

(Place Seal Imprint Here)

My Commission Expires: _____